DDAS Accident Report

Accident details

Report date:	21/01/2008	**Accident number:**	493
Accident time:	Not made available	**Accident Date:**	02/06/2007
Where it occurred:	Tourkotal Village, Daman district, Kandahar Province	**Country:**	Afghanistan
Primary cause:	Field control inadequacy (?)	**Secondary cause:**	Other (?)
Class:	other	**Date of main report:**	Not recorded
ID original source:	None	**Name of source:**	UNMACA
Organisation:	[Name removed]		
Mine/device:	AP blast (unrecorded)	**Ground condition:**	hard metal fragments
Date record created:		**Date last modified:**	21/01/2008
No of victims:	1	**No of documents:**	1

Map details

Longitude:		**Latitude:**	
Alt. coord. system:	Not recorded	**Coordinates fixed by:**	
Map east:		**Map north:**	
Map scale:		**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

inadequate investigation (?)

squatting/kneeling to excavate (?)

metal-detector not used (?)

Accident report

A letter about this accident was made available in August 2007 as a PDF file. Its conversion to a text file for editing means that some of the formatting has been lost. The substance of the letter is reproduced below, edited for anonymity. The original PDF file is held on record. Text in [ ] is editorial. This record will be revised if the full investigation report is made available in future.

LESSONS LEARNED SUMMARY

DEM ACCIDENT ON DEMINER OF [National demining agency] DT # 4

AT TOURKOTAL VILLAGE, DAMAN DISTRICT OF KANDHAR PROVINCE

ON 2nd JUNE 2007

[Letter undated]

INTRODUCTION:

On 2nd June 2007, a demining accident occurred to deminer of [National demining agency] named [the Victim] at MF # AF/2402/00000/MF192 located at Tourkotal village, Daman district of Kandahar province. As the involved deminer had used the PPE properly, he has not received any injuries.

SUMMARY:

According to the AMAC South investigation report, the deminer was tasked by Team Leader/Section Leader to clear a cross lane on a portion of the minefield heavily contaminated by fragments whilst required full excavation. As the detector indicated multiple signals, the deminer started excavation on the readings with a local made bayonet. Excavation was carried out about 30 cm without confirming the excavated area with metal detector. While excavating, the bayonet touched the mine's pressure plate and was detonated.

The ground was hard, excessive pressure might have been applied on the mine by the deminer. After the accident, it was observed that the area had not been excavated to the required depth and two additional signals were found undetected on the excavated portion.

Fortunately, as the involved deminer had properly used PPE therefore received no injuries.

CONCLUSIONS:

The investigation team concluded that the accident occurred because of the following reasons:

1. The excavation drill was not practiced in accordance with the SOP because the deminer excavated forward up to 30 cm but did not use metal detector to check the excavated area; moreover, the depth of excavation was not properly maintained.
2. Incorrect excavation drill is considered as one of the contributing factors to the accident.
3. The section leader should have notified the deminer to use detector for re-confirming the signal's exact location.
4. This team had planned to go for mission leave on 30th May 2007 but suddenly the team's mission duration had been extended for extra 10 days. Extension of the mission duration may have mentally stressed the deminer.

RECOMMENDATIONS:

The following points are to be considered:

1. Refresher training is recommended for the team members, concentrating on excavation drill.
2. The agency should have properly planned the OPS mission and Leave mission for its teams and to communicate it to the respective teams in advance.
3. Team's command group to ensure that the deminers apply all the demining drills correctly, safely and systematically.

Signed: Chief of Operations, UNMACA Kabul

Victim Report

Victim number:	655	**Name:**	[Name removed]
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	yes
Compensation:	Not appropriate	**Time to hospital:**	Not appropriate
Protection issued:	Frontal apron Long visor	**Protection used:**	Frontal apron, Long visor

Summary of injuries:

COMMENT: Non-injurious accident. No medical report was needed.

Analysis

The primary cause of this accident is listed as a "Field control inadequacy" because the lessons learned included the fact that the Victim was not working to his SOPs and his errors were not corrected.

The secondary cause is listed as "Other" because there is not enough information to assess the details surrounding this accident.

This record will be revised if the full investigation report is made available in future.